PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd Oct 3 1945

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69103

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Seneca
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 40 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Seneca
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Anderson

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mamie Anderson Seneca, Md.
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) April 18, 1882

8. AGE: Years 63 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Front Royal, Virginia (Town, county, and state)
10. Usual occupation Farm hand.
11. Industry or business

FATHER
12. Name Henry Anderson
13. Birthplace Virginia

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant Mamie Anderson (wife)
Address Seneca, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25, 1945 (month) (day) (year)
Cemetery or crematory Senca Cemetery
Location Senca Md.

18. Funeral director Robert L. Snowden
Address Rockville Md.

19. Sep 23 1945 (Date rec'd by registrar) Upton D. Bowse M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1945, at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1945, to Sept 22 1945
and that I last saw him alive on Sept 22 1945

Immediate cause of death	DURATION
Carcinoma of Liver	
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. or other
Address Gaithersburg Date signed Sept 23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-L

9164

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Glen Echo Hgts.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Winnebago rd 6410

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 22 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Glen Echo Hgts. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Winnebago rd - 6410
(If rural, give LOCATION)

2(a) IF VETERAN, NAME WAR none.

3. (a) FULL NAME Thomas Foster Ardinger

3. (b) Social Security Number 217-14-7609

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single.

6 (b) Name of husband or wife none

6(c) If alive, give age none years

7. Birth date of deceased (mo., day, yr.) January 31 1922.

8. AGE: Years 23. Months 9 Days 1 If less than one day ____ hrs. ____ min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation mechanic

11. Industry or business

FATHER 12. Name Harry Ardinger

13. Birthplace Washington D.C.

MOTHER 14. Maiden name Myra Rogers.

15. Birthplace Virginia

16. Informant Harry Foster. father Address 6410 Winnebago Wash. D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof Sept 1 1945 (month) (day) (year)

Cemetery or crematory

Location Wash. D.C.

18. Funeral director A. W. Chambers Co.

Address 3072 - M St. N.W.

19. 9-1-45 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1945, at 7:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17, 1945 to Sept 1, 1945 and that I last saw him alive on Sept 1, 1945

Immediate cause of death Acute pneumonic Pleurisy — DURATION 5 days.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. L. Bauerfeind M.D.
M. D. or other

Address Bethesda Md. Date signed 9/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-c)

CERTIFICATE OF DEATH

C-9105

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months & 18 days

Hospital, Institution, or street address where death occurred:
Cedarcroft Sanitarium, Silver Springs

How long in hospital or institution? 4 months & 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Washington County:

City or town: Bothell
(If outside city or town limits, write RURAL and give nearest town)

Street No. RR #2, Box 512 A,
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BARNETT, Harold Joseph, Lt.(jg) USN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Mrs. Gladys G. Barnett

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-27-07

8. AGE: Years	Months	Days	If less than one day
37	11	21	hrs. min.

9. Birthplace: Kansas
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Wife: Mrs. Gladys G. Barnett
Address: RR #2, Box 512 A, Bothell, Wash.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 9-21-45 (month) (day) (year)

Cemetery or crematory:

Location: Seattle, Washington

18. Funeral director: Geo. W. Wise, J C F.
Address: 2900 M St., N. W., Wash., D.C.

19. 9-19 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 19 45, at 11:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Pulmonary, adena	
Due to alcoholism, acute	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchat M.D. Asst. Med. Exam M. D. or other

Address: Whitesburg, Md. Date signed: 9-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

69106

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery County
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 741 Butternut St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bassett, Isaac.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Edna L.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 16, 1876.

8. AGE:

Years	Months	Days	If less than one day
69	1	1	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: L. A. Bassett
13. Birthplace: Washington, D.C.
MOTHER 14. Maiden name: Zimmerman
15. Birthplace: Washington, D.C.
16. Informant: Hospital Records
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20 1945 (month) (day) (year)
Cemetery or crematory: Congressional Cem
Location: Washington D.C.
18. Funeral director: Wasthe Funeral Home
Address: 301 E. Capitol St. Wash DC
19. 9/17 1945 Wm E Jubert
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 17 1945, at 8:10 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Sept 17 1945
and that I last saw h[illegible] alive on 16 1945
Immediate cause of death: Cerebral Hemorrhage — OURATION
Due to: Hypertension — 5 yrs ?
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John N. Andrew M.D.
M. D. or other
Address: 9601 Colesville Road Silver Spring Md. Date signed: 9-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-9)

CERTIFICATE OF DEATH

09107

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest towo)

How long in above place of death? 18 hours

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 18 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn iofants give residence of mother)

State District of Columbia County

City or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5208 44th St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Elizabeth Veronica Bieber

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife William Eugene Bieber

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) March 12, 1903

8. AGE: Years	Months	Days	If less than one day
42	6	7	....hrs. ....min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Elwood Twigg

13. Birthplace Cumberland Md.

MOTHER 14. Maiden name Elizabeth Conners ?

15. Birthplace

16. Informant William Eugene Bieber

Address 5208 44th St., N.W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 19 45 (month) (day) (year)

Cemetery or ~~crematory~~ Fort Lincoln

Location 3201 Bladensburg Rd. N.E. - Md.

18. Funeral director L. S. Ives Co.

Address 2901-14. N.W. Wash., D.C.

19. 9/19 19 45 Wm E Jules (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945 at 7:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 Med Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
(a) Acute Coronal Lung	20 hrs.
Due to (b) (Embolism)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-19-45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D. M. D. or other

Address Gaithersburg Md Date signed 9-19-45

09108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, Institution, or street address where death occurred:
USNH. Bethesda Md.

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: Arlington

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 812 S. Glebe Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Alice Bowling

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Samuel Bowling, Jr.

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): 6-5-19

8. AGE: Years	Months	Days	If less than one day
26	3	8	..... hrs. ..... min.

9. Birthplace: Bluefield, W.Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: CABELL N. PAYNE
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: ALICE PAYNE
15. Birthplace: NEW YORK

16. Informant: Samuel Bowling, Jr.
Address: 812 S. Glebe Rd. Arlington Virginia

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 9-29-45 (month) (day) (year)

Cemetery or crematory:

Location: Bluefield, W.Va.

18. Funeral director: W.W. Chamberlain Co. Inc.
Address: 1400 Chapin St. N.W. Wash. D.C.

19. 29 Sept. (Date rec'd by registrar) 19 45 Mary Charlotte Smith M.C. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28 19 45 at 5.45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 Med. Exam case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Diabetic Mellitus	2½ mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brosnahan M.D.
Dep. Med. Exam M. D. or other

Address: Montgomery Co. Md. Date signed: 9-29-45

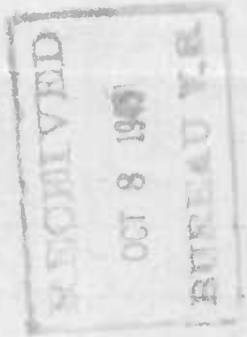
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 10/12

REMAINS RELEASED TO DISTRICT AUTHORITY

Frank J. Broschart M.D.
Frank J. Broschart, M.D.
Deputy Medical Examiner
for Montgomery County, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

C9169

★ Reg. Dist. No. 2-13

1. PLACE OF DEATH:

County: Montgomery

City or town: Montgomery County Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred: Sandy Springs Olney md

How long in hospital or institution? 2 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural R-F-D Rockville md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Cora E Bowling

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife: John W Bowling

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11 - 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70.	3	14		

9. Birthplace: Georgia (Town, county, and state)

10. Usual occupation: Home

11. Industry or business: None

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Edward E Bowling

Address: Rockville R-F-D

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 28 1945 (month) (day) (year)

Cemetery or crematory: Potomac md

Location: Montgom Co md

18. Funeral director: Roy W Barber

Address: Rockville md

19. 9-27-45 (Date rec'd by registrar) 19 Josephine D Hostetter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 25 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1945 to Sept 25 1945

and that I last saw her alive on Sept 25 1945

Immediate cause of death	DURATION
Cerebral apoplexy	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G O Hartley M.D. M. D. or other

Address: Rockville Md Date signed 9/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (926)

CERTIFICATE OF DEATH

(9110)

★ Reg. Dist. No. 223

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution, or~~ street address where death occurred:
24 COLUMBIA. AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 COLUMBIA. AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war: NONE.

3.(a) FULL NAME: CHARLES EDWARD BRERETON.

3.(b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE.	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): JAN - 10 - 1858.

8. AGE: Years	Months	Days	If less than one day
87	8	16.	..... hrs. ..... min.

9. Birthplace: WASHINGTON - D.C.
(Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business

FATHER
12. Name: WILLIAM H BRERETON
13. Birthplace: WASHINGTON. D.C.

MOTHER
14. Maiden name: GEORGIA ANNA TAYLOR
15. Birthplace: PENNA.

16. Informant: LOUISE BRERETON.
Address: 24 COLUMBIA AVE - TAKOMA PARK.

17. BURIAL. Date thereof: SEPT 28 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery ~~or crematory~~: ROCK CREEK.

Location: WASHINGTON. D.C.

18. Funeral director: Warner & Pumphrey.

Address: 8024 - GA AVE. SILVER SPRING MD

19. Sept 27 1945 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1945, at 1:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Sept. 26 1945

and that I last saw h.i.m. alive on Sept. 26 1945

Immediate cause of death	DURATION
Cardiac dilatation	1 day
Due to: Mitral regurgitation	
general debility of age	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. A Shannon M. D
M. D. or other

Address: 123 Carroll St. N.W. Wash. D.C. Date signed: 9-26-45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

09111

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 14 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 mos. 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: D. C.

City or town: Parkland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 225 Maryland Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary (n) Brightly

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	Married

6.(b) Name of husband or wife: Arthur Louis Brightly

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 15, 1909

8. AGE: Years	Months	Days	If less than one day
36	6	5	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Julius Gottlied
13. Birthplace: Russia

MOTHER
14. Maiden name: Alida Walters
15. Birthplace: Russia

16. Informant: Husband: Arthur L. Brightly
Address: 225 Maryland Ave., Parkland, Md

17. burial (Burial, cremation, or removal. Which?) Date thereof 9-24-45 (month) (day) (year)

Cemetery or crematory: Washington National

Location: Suitland, Md.

18. Funeral director: Wm. J. Nalley

Address: 522 8th St., S. E., Wash., D.C.

19. 20 Sept. 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 September 19 45, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 July 19 45, to 20 Sept. 19 45

and that I last saw her alive on 19 Sept. 19 45

Immediate cause of death: Acute Myelogenous Leukemia — DURATION: 10 Mont

Due to:

Due to:

Other conditions: Severe Secondary Anemia
Hemorrhages + Abdominal Ascites
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Wide Spread Leukemic Infiltrations

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gordon R. Lamb M. D. or other

Address: U.S. Naval Hospital Bethesda Date signed 9/20/45

VS A15 ✓

9/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (d)

CERTIFICATE OF DEATH

(9112)

★ Reg. Dist. No. 211

1. PLACE OF DEATH:
County: Montgomery
City or town: Brownsville MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: Montgomery
City or town: Brownsville MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Moody M. Burdette

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ellen G. Burdette
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Oct 5.th 1884

8. AGE: Years	Months	Days	If less than one day
60	11	14	...hrs. ...min.

9. Birthplace: Montgomery County MD.
(Town, county, and state)
10. Usual occupation: Merchant Retired
11. Industry or business: Store

FATHER
12. Name: Joseph M. Burdette
13. Birthplace: Montgomery County MD.

MOTHER
14. Maiden name: Isabell Watkins
15. Birthplace: Montgomery County MD.

16. Informant: MRS. Ellen Burdette
Address: Brownsville MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 21 1945 (month) (day) (year)
Cemetery or crematory: Bethesda
Location: Brownsingsville
18. Funeral director: Roy W. Barber
Address: Laytonsville MD.

19. Sept-21 19 45 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1945, at 9:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 1942, to September 19 1945
and that I last saw h.. l.. alive on September 15, 1945

Immediate cause of death	DURATION
Coronal Thrombosis, left	2 weeks.
Due to Diabetes mellitus	10 years.
Due to Arteriosclerotic cardio vascular disease	5 years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James R. Kerr M. D.
M. D. or other
Address: Damascus, Md. Date signed: 9/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(9113

CERTIFICATE OF DEATH

★ Reg. Diat. No. 216

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Suburban Hospital

Stay in hospital or inst. (yrs., or mos., or days) 0 hr. 20 min

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Dist of Columbia County

City or town Washington D.C. Ward No. (If outside city of town limits, write RURAL NEAR and give town)

Street No. 3000 Tilden St. N.W. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Frank B. Burdsall

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife Rena O. Burdsall

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 9, 1881

8. AGE: Years	Months	Days	If less than one day
64	4	—	____ hrs. ____ min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual occupation Res. Mgr. Ins. Co.

11. Industry or business Res. Mgr Ins. Co.

FATHER 12. Name Francis P. Burdsall

13. Birthplace Kentucky

MOTHER 14. Maiden name Barber

15. Birthplace New Jersey

16. Informant Mrs. Rena Burdsall

Address 3000 Tilden St. N.W. Wash.

17. (Burial, cremation, or removal? Which?) Date thereof Sept 9, 1945 (month) (day) (year) Sept 203

Cemetery or crematory Oak Hill

Location Jos. Gawler's Sons.

18. Funeral director Gawler Undertaking Co.

Address 1756 Penna Ave, Dist of Col.

19. 9/9 1945 (Date rec'd by registrar) Wm E Jaber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1945, at 12:29 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8 1945 to Sept 9 1945, and that I last saw h-m alive on Sept 9 1945

Immediate cause of death	DURATION
Rupture aneurysm aorta.	6 hrs +
Due to aneurysm aorta at ilium bi-fur cation	1 yr +
Due to Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy Confirmation above.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Edward Hughes M.D. M. D. or other

Address 1726 Eye St. N.W. Washington D.C. Date signed 9/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-C)

CERTIFICATE OF DEATH

69114

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery Co.

City or town: Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred: 805 maple ave.

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Florida Pk Bowie (MD)

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4810 Fox St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Lettie M. Cable

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: E. L. Cable

7. Birth date of deceased (mo., day, yr.): Oct 15 - 1871

6.(c) If alive, give age: ..... years

8. AGE: Years	Months	Days	If less than one day
74	11	15	..... hrs. ..... min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER — 12. Name: W. S. Moore

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Lettie Prather

15. Birthplace: Unknown

16. Informant: Miss Louella E. Cable

Address: 4810 Fox St Daniels Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 1 1945 (month) (day) (year)

Cemetery or crematory: Riverview Cemetery

Location: Chamberlain South Dakota

18. Funeral director: F. Gaskill Sons

Address: Hyattsville Md

19. Oct 1 1945 (Date rec'd by registrar) J Wilson Lloyd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30, 1945, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19, 1945, to Sept 30, 1945 and that I last saw h.. alive on Sept 30, 1945

Immediate cause of death	DURATION
Mitral regurgitation	duration
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. B. Little M.D. M.D. or other

Address: 691 S. 4th st. Washington D.C. Date signed: 9/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-5

CERTIFICATE OF DEATH

★ 09115

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, institution, or street address where death occurred:

47 Baltimore St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Mont'g

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 47 Baltimore St

(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1

3. (a) FULL NAME: Hubert O. Calvery

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Gertrude V.

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 7. 1898

8. AGE: Years	Months	Days	If less than one day
47			..... hrs. ..... min.

9. Birthplace: Texas (Town, county, and state)

10. Usual occupation: Pharmacist

11. Industry or business

FATHER — 12. Name: Luther Calvery

13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Theresa Marricle

15. Birthplace: South Carolina

16. Informant: Mrs. Gertrude Calvery

Address: 47 Balt. St. Ken

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/26/45 (month) (day) (year)

Cemetery or crematory: Rockville Union Cem

Location: Rockville, Md.

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda

19. 9/25 19 45 Wm E Jahn Jr. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23 19 45 at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1st Med. Exam 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Poisoning (Probably Cyanide)	duration Instantaneous
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 9-23-45

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Frank J. Bromhardt M. D.

23. SIGNATURE: Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed 9-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
SEP 26 1945
BUREAU V.S.

(9115

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 213

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary L. Carroll.

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(c) Single, married, widowed, or divorced
female	Colored	Single

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1865

8. AGE: Years 80 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business

FATHER 12. Name: James W. Carroll

13. Birthplace: Maryland.

MOTHER 14. Maiden name: Margaret Norris

15. Birthplace: Maryland.

18. Informant: Elizabeth Hartman

Address: Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1, 1945 (month) (day) (year)

Cemetery or crematory: Hadi

Location: Rockville, Md.

18. Funeral director: Robert L. Snowden

Address: 246 N. Washington St. Rockville

19. 10-1-45 (Date rec'd by registrar) 19 Josephine D. Mattingly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 19 45 at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 42 to Sept 29 19 45

and that I last saw h ... alive on Sept 29 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 Hours
Due to: Hypertension	10 Years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Wallace Welch 2-D.

M. D. or other

Address: Rockville, Md Date signed 10/1/45

(9117

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1175)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 15 days

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 3 mos. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest towo)

Street No. 1211 59th Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3. (a) FULL NAME

Wing S. CHING, ChC USN Retired Active

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Chinese-US	Married

6.(b) Name of husband or wife: Eva Ching

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 15 1886

8. AGE: Years	Months	Days	If less than one day
58	10	28	..... hrs. ..... min.

9. Birthplace: Honolulu, Hawaii
(Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business

FATHER
12. Name: Ching Lee Luuk
13. Birthplace: China

MOTHER
14. Maiden name: Yee
15. Birthplace: China

16. Informant: Wife: Mrs. Eva Ching
Address: 1211 59 Ave. E, Capitol Heights, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9-20-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va

18. Funeral director: Geo W. Wise J.C.F.

Address: 2900 M St., N.W., Wash., D.C.

19. 14 Sept. 1945 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1945, at 7.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 1945, to Sept 13 1945 and that I last saw him alive on Sept 13 1945

Immediate cause of death	DURATION
Peritonitis, General	3 hrs.
Due to: Ulcer Stomach	Unknown
Due to:	
Other conditions: Anuria	1 day.

(Include pregnancy within 3 months of death)

Major findings of operations: Ulcer, stomach

Date of op. 9-11-45

Autopsy results: Peritonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: (L.E. Gilpin) M. D. or other

Address: U.S. Naval Hosp. Bethesda Date signed: 9-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(9-19-45) VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C9118

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

How long in above place at death?

Hospital, institution, or street address where death occurred:
805 FLOWER AVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: MONTGOMERY

City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

Street No. 805 FLOWER AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: BELINDA CATHERINE CLARK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	WIDOWED

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MARCH 27, 1867

8. AGE:

Years	Months	Days	If less than one day
78	5	14	..... hrs. ..... min.

9. Birthplace: ELKHART, INDIANA.
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: JACKSON C. HULL
13. Birthplace: OHIO.

MOTHER
14. Maiden name: ANGELINE ECHART
15. Birthplace: ELKHART, INDIANA.

16. Informant: MISS BERTHA L. HULL
Address: 805 FLOWER AVE, TAKOMA PARK, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: SEPT. 14, 1945. (month) (day) (year)

Cemetery or crematory

Location: Chicago, Illinois.

18. Funeral director: J. Arthur Dolley.

Address: 254 Carroll Ave. N.W., Takoma Park, D.C.

19. Sept 10 1945 (Date rec'd by registrar) John Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT. 10, 1945, at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1943 to Sept 9 1945 and that I last saw h.e. alive on September 9, 1945

Immediate cause of death	DURATION
Myocarditis, chronic	3 yrs
Cardiac Decompensation	7 mo.
Due to Arteriosclerosis	10 yrs. ?
Due to	
Other conditions Rheumatoid Arthritis Chronic (Include pregnancy within 3 months of death)	8 yrs

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Wallace U. Mook M.D.
M. D. or other

Address: 805 Carroll Ave. Date signed: 9-10-45
Takoma Park 12, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)+

CERTIFICATE OF DEATH

C9119 Reg. Dist. No. 716

VS A15 ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 2 mo. 11 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4624 Chestnut Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Colburn, Pearl L.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: David Colburn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 2, 1905

8. AGE: Years	Months	Days	If less than one day
40	3	27	..... hrs. ..... min.

9. Birthplace: Darnestown, Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: C. P. C. Ricketts

13. Birthplace: Quince Orchard Md.

MOTHER 14. Maiden name: Catherine Kelly

15. Birthplace: Derwood, Md.

16. Informant: Hospital Records

Address: Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/2/45 (month) (day) (year)

Cemetery or crematory: Darnestown Cem.

Location: Darnestown, Md.

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda, Md.

19. 10/1 1945 (Date rec'd by registrar) Mrs E. Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/29 1945, at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to Sept 29 1945

and that I last saw her alive on Sept 27 1945

Immediate cause of death	DURATION
Bronchial pneumonia	2 days
Due to: Widespread metastatic carcinoma	2 years
Due to: Primary carcinoma of left breast	3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Bruce F. Benjamin M.D. M. D. or other

Address: Bethesda, Md. Date signed 9/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md.)

CERTIFICATE OF DEATH

(9120

★ Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Usual~~ street address where death occurred:

Poplar Ave. Hollywood

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. Poplar Ave. Hollywood

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME

LAURA BAKER CRAWFORD

3.(b) Social Security Number

no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: James P.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 17th. 1856

8. AGE: Years	Months	Days	If less than one day
89	2	9	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: William E. Baker

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary C. Hopkins

15. Birthplace: Mont. Co. Md.

16. Informant: Mrs. Pearl C. Milstead, daughter

Address: 3426 - 16th. St. N. W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/28/45 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington, D. C.

18. Funeral director: Wames & Pumphrey

Address: 8434 Ga. Ave. Silver Spring. Md.

19. Sept 27 1945 (Date rec'd by registrar) Josephine McKaffee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1945, at 11:45a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1938, to September 26 1945.

and that I last saw h.er alive on August 29 1945

Immediate cause of death	DURATION
Heart Failure	
Sudden death	
Due to Chronic Valvular Heart Disease	10 years
Due to Arteriosclerosis with arterial hypertension	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. H. Howlett, M.D. M.D. or other

Address: 928 Sligo ave., Silver Spring, Md. Date signed: Sept 27, 1945

Coronor notified of this death and approved the issuance of death certificate by me.

H. H. Howlett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09121

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Monty

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo.

Hospital, institution, or street address where death occurred:

4608 N. Chelsea St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Ohio County: Lucas

City or town: Toledo

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3724 Lockwood St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Charles James Crofts

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary E. Crofts

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 21 1868

8. AGE: Years	Months	Days	If less than one day
77	0	10	hrs. min.

9. Birthplace: Lucas Co. Ohio

(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business

FATHER

12. Name: Thomas E. Crofts

13. Birthplace: Liverpool - England

MOTHER

14. Maiden name: Emma Von Waldeck

15. Birthplace: Ohio

16. Informant: Charlotte Ann Taylor

Address: 4609 N. Chelsea St.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof: 9/3/45 (month) (day) (year)

Cemetery or crematory: Toledo, Ohio

Location: Toledo, Ohio.

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis Ave. Bethesda

19. 9/3 19 45 Wm E Jones Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1 19 45 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bronhard M.D.

Dec. Med. Exam M. D. or other

Address: Gaithersburg md Date signed: 9-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09122

FILM No. G 98 OCT 4 1945

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Ten Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

Street No. #11 Leland Street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: EDGAR C. CROSBY.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Winifred D. Crosby

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): March 19, ~~1883~~ 1884

8. AGE: Years	Months	Days	If less than one day
61	5	28	..... hrs. ..... min.

9. Birthplace: New Bedford, Massechusetts (Town, county, and state)

10. Usual occupation: Government Employee

11. Industry or business: O.P.A.

FATHER 12. Name: Edgar B. Crosby

13. Birthplace: Mass.

MOTHER 14. Maiden name: Adeline Spooner

15. Birthplace: Mass.

16. Informant: Edgar C. Crosby, Jr.

Address: #11 Leland Street, Ch. Ch., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20, 1945 (month) (day) (year)

Cemetery or crematory: Mount Olivet Cemetery

Location: Washington, D.C.

18. Funeral director: James T. Ryan, Inc.

Address: 317 Penna. Ave., S.E.

19. Sept 18 1945 (Date rec'd by registrar) Josephine McSchaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17, 1945 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14, 1945, to Sept. 17, 1945 and that I last saw h... alive on Sept 17, 1945

Immediate cause of death	DURATION
Coronary Thrombosis.	1 hour.
Due to	
Due to	
Other conditions: Grippe, with Congestion & Emphysema.	4 days.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Connor M. D. (M. D. or other)

Address: 2036-16th St. N.W. Date signed: 9/17/45

Washington, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

(9123

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 217

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I. PLACE OF DEATH:

County: Mont Gomery Co

City or town: Norbeck

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha E. Harsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1866

8. AGE:

Years	Months	Days	If less than one day
79			hrs. min.

9. Birthplace: Norbeck, Maryland (Town, county and state)

10. Usual occupation: Housekeeper.

11. Industry or business

FATHER 12. Name: William Johnson

13. Birthplace

MOTHER 14. Maiden name: Martha Johnson

15. Birthplace: Norbeck, Md.

16. Informant: Malgelia Hams

Address: Norbeck, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4 1945 (month) (day) (year)

Cemetery or crematory: Norbeck, Cem.

Location: Norbeck, Maryland

16. Funeral director: R. L. Snowden.

Address: 246 N. Wash. St. Rockville, Md.

19. 9-4-1945 (Date rec'd by registrar) Gertrude B. Lamb Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July-31-1945 to Sept 1- 19..; and that I last saw her alive on aug 29- 19..

	DURATION
Immediate cause of death: aft hemiplegia	32 days
Due to: General arteriosclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles Tompleson M. D. or Clerk

Address: Sandy Spring, Md. Date signed: 9/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

09124

★ Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Gaithersburg Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Isaac M Easton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6.(b) Name of husband or wife: Laura Ann Easton

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): January 7 - 1869

8. AGE:

Years	Months	Days	If less than one day
76	8	9	____ hrs. ____ min.

9. Birthplace: Montgomery County Md (Town, county, and state)

10. Usual occupation: Sheet Metal Worker

11. Industry or business: Metal Roofing & tinwork

FATHER — 12. Name: Silas Easton

FATHER — 13. Birthplace: Montgomery Co Md

MOTHER — 14. Maiden name: Elizabeth Ann Hilton

MOTHER — 15. Birthplace: Montgomery Co Md

16. Informant: Elwood H Easton

Address: Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17 - 1945 (month) (day) (year)

Cemetery or crematory: Forest Oak

Location: Gaithersburg Md

18. Funeral director: Roy W Barber

Address: Gaithersburg Md

19. Sept 17 1945 Almeda L Cooke

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 - 1945 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July - 1 - 1945 to Sept - 15 - 1945 and that I last saw him alive on Sept - 15 - 1945

Immediate cause of death	DURATION
acute heart failure (dilatation	2-3 hours
Due to: chronic myocarditis -	2-3 yrs
Due to: Arterio-sclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: H. C. Miller, M.D. (M. D. or other)

Address: Gaithersburg, Md Date signed: 9/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-a)

CERTIFICATE OF DEATH

69125

Reg. Dist. No. 2-16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: 4006 Leland St.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chevy Chase
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sheridan Ferree

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Erma

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 21, 1869

8. AGE:

Years	Months	Days	If less than one day
76	1	5	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation

11. Industry or business: Retired

FATHER
12. Name: Newton Ferree
13. Birthplace: Pa.

MOTHER
14. Maiden name: Rose Utensheal
15. Birthplace: Wash. D.C.

16. Informant: Newton Ferree, (Son)
Address: Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/29/45 (month) (day) (year)
Cemetery or crematory: Arlington Natl. Cem.
Location: Virginia

18. Funeral director: Wm Reuben Pumphrey
Address: Bethesda, Md.

19. 9/26 1945 Wm E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 26, 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Post-operative Hemorrhage and Shock	
Due to: Transurethral Prostatectomy	
Due to: Prostatic Hypertrophy	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: See Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Richard S. Kelso M.D.
M. D. for other
Address: Bethesda, Md. Date signed 9-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 548 +

CERTIFICATE OF DEATH

Reg. Dist. No. (9126) 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Mont'g

City or town: Dickerson
(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD #2
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War (Pvt. AUS)

3.(a) FULL NAME

FIELDS, Roger Earl

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 9, 1893

8. AGE: Years	Months	Days	If less than one day
52	3	9	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business

FATHER
12. Name: Clayton S. Fields
13. Birthplace: Md.

MOTHER
14. Maiden name: Fannie Fields Wood
15. Birthplace: Md.

18. Informant: Sister: Mrs. Robert Long
Address: 300 Rittenhouse St., N.W., Wash., D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 9-19-45 (month) (day) (year)

Cemetery or crematory: [illegible]

Location: Bealsville, Md.

18. Funeral director: W. W. Chambers

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 9-19 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-18 19 45, at 1:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-10- 19 45, to 9-18 19 45 and that I last saw him alive on 9-17 19 45

Immediate cause of death	DURATION
Respiratory paralysis	
Due to: Increased intracranial pressure	
Due to: Brain tumor, malignant.	
Other conditions contributing to death but not related to terminal disease: Hypertension. Unknown. Cirrhosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: USNHB, Bethesda, Md. Date signed: 9-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

9/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 36

CERTIFICATE OF DEATH

69127

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? five days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Md.

How long in hospital or institution? five days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Mass. County:

City or town: N. Andover

(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 Great Pond Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

GAGE, Kenneth Atkinson, Mus 2c USN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-17-19

8. AGE:	Years	Months	Days	If less than one day
	26	6	29	hrs. min.

9. Birthplace: Mass. (Town, county, and state)

10. Usual occupation: Navy School of Music

11. Industry or business:

FATHER

12. Name: George H. Gage

13. Birthplace: Mass.

MOTHER

14. Maiden name: Mildred Atkinson

15. Birthplace: Mass.

16. Informant: Father: Mr. George H. Gage

Address: 100 Great Pond Rd., N. Andover, Mass.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9-18-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Geo. W. Wise, F.F.F.

Address: 2900 M St., N. W., Wash., D.C.

19. 9-17-45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 Sept. 1945 at 10:40a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Sept. 1945, to 16 Sept. 1945 and that I last saw him alive on 16 Sept. 1945

Immediate cause of death	DURATION
acute anterior poliomyelitis (Bulbar type)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. F. ECKARDT, Lt. (MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(9/17/45)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

★ 09128

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Forest Glen

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rosenstel Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Forest Glen Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Rosenstel Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary L. Germane

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Dudley Germane

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1865

8. AGE: Years	Months	Days	If less than one day
80	3	22	hrs. min.

9. Birthplace Washington D C (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name John C White

13. Birthplace England

MOTHER 14. Maiden name Isabelle Vibert

15. Birthplace England

16. Informant Mr George Muse

Address Rosenstel ave Forest Glen md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 18 1945 (month) (day) (year)

Burial Sept 21 1945

Cemetery or crematory Glenwood Cemetery

Location Washington D.C.

18. Funeral director Frank Geiers Sons Co

Address 3605-14 St N W Wash. D.C.

19. Sept 18 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1945, at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to Sept 18 1945, and that I last saw h-- alive on Sept 17 1945.

	DURATION
Immediate cause of death Myocarditis	2 yrs
Due to Arteriosclerosis	8 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. W. Fulton M.D.

M. D. or other

Address 3781 Calvert St N W Date signed 9/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

09129

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution~~ or street address where death occurred:

White Oak

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: White Oak - Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: WILLIAM JOHNSON GIDDINGS

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of ~~husband~~ or wife: Mary Adelaide

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 12th. 1861

8. AGE: Years	Months	Days	If less than one day
83	10	18	..... hrs. ..... min.

9. Birthplace: Leesburgh, Va. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Charles Glenville Giddings

13. Birthplace: Frederick Co. Md.

MOTHER 14. Maiden name: Dorcas Hempstone

15. Birthplace: Va.

16. Informant: Mrs. John R. Clark, daughter

Address: White Oak, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/26/45 (month) (day) (year)

Cemetery or ~~Crematory~~: St. Marks

Location: Fairland, Montg. Co. Md.

18. Funeral director: Warner E. Pumphrey

Address: 8434 Ga. Ave. Silver Spring, Md.

19. Sept. 25 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1945, at 3 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. When 19 Assumed (over) 19

and that I last saw h... alive on 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	Sudden
Due to	
Due to	
Other conditions: Hypertension Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Marion Bamford M.D. M. D. or other

Address: Silver Spring, Md. Date signed 9/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

This patient had been under care of Dr. C. W. Mitchell, Silver Spring, Md. and was seen by him 3 days ago. Dr. Mitchell is out of the city so I was called, and patient was dead when I arrived. Dr. Broschart, county coroner, was notified and O.K'd issuance of this certificate by me.

J. Marion Beachead

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

09130

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6507 Maple Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Della Gilmore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife John F.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1865

8. AGE: Years	Months	Days	If less than one day
80			hrs. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Nathan D. Hendricks
FATHER 13. Birthplace Del.
MOTHER 14. Maiden name Margaret Swearenger
MOTHER 15. Birthplace unknown
16. Informant Norman G. Hough
Address 6507 Maple Ave.
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 9/8/45 (month) (day) (year)
Cemetery or crematory Leisure Cem.
Location Leisure Ohio
18. Funeral director Wm Reiber Pumphrey
Address Bethesda Md.
19. 9/8 19 45 Wm E Dobbs
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945 at 3 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Sept 6 1945
and that I last saw h alive on August 2 1945
Immediate cause of death a. Pernicious anemia — DURATION 10 years
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John Logan M.D.
M. D. or other
Address 1001 Nevada Ave NW Date signed Sept 7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09131

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yr
Hospital, Institution, or street address where death occurred:
9625 Lawndale Dr
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9625 Lawndale Dr
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Christian L. Gliem

3.(b) Social Security Number: 579-09-8500

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Evelyn M. Gliem
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): April 13 1894

8. AGE: Years	Months	Days	If less than one day
51	7	22	...hrs. ...min.

9. Birthplace: Washington DC
(Town, county, and state)
10. Usual occupation: Refrigeration repair
11. Industry or business

FATHER
12. Name: Christian P. Gliem
13. Birthplace: Pa

MOTHER
14. Maiden name: Eva V. Childs
15. Birthplace: Wash. DC

16. Informant: Evelyn M. Gliem
Address: 9625 Lawndale Dr. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 7 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md

18. Funeral director: Jos. Gawler's Sons
Address: 5-6 Pa Ave NW

19. Sept 5 1945 (Date rec'd by registrar) Josephine M. Schaeffe, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 19 45 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 19 45 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Burchat M.D.
Pa. Med. Exam. M. D. or other
Address: Gaithersburg Md Date signed: 9-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5-a)

CERTIFICATE OF DEATH

09132

Reg. Diat. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
9508 Bilmore ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9508 Biltmore Ave.
(If roral, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Gertrude Amelia Greiner

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widow

6.(b) Name of husband or wife: Joseph L. Greiner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 8th 1879

8. AGE: Years	Months	Days	If less than one day
65			..... hrs. ..... min.

9. Birthplace: Altoona Pa
(Town, county, and state)
10. Usual occupation: none
11. Industry or business: none
FATHER 12. Name: William Feather
13. Birthplace: Pa
MOTHER 14. Maiden name: Mary Yarbrough
15. Birthplace: Pa
16. Informant: Mrs John W. Wertzberger
Address: 322 10th St S.E. DC
17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-5-45 (month) (day) (year)
Cemetery or crematory: Washington DC
Location:
18. Funeral director: W. W. Chambers Co
Address: 517 11th St S.E. DC
19. Sept 5 (Date rec'd by registrar) 19 45 Josephine M. Keefe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1945 at 5:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945 to Sept. 5 1945 and that I last saw h.. alive on Sept. 4 1945

Immediate cause of death	DURATION
Cardiac dilatation	sudden
Due to	
Due to	
Other conditions: Atrophic arthritis, decubitus ulcers general debility	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Shannon M.D.
M. D. or other
Address: 113 Carroll St N.W. Date signed Sept. 5 '45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9133

Reg. Dist. No. 212

1. PLACE OF DEATH:
County: Montgomery
City or town: Poolesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg
City or town: Poolesville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: REBECCA HALL

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 30 - 1869

8. AGE:

Years	Months	Days	If less than one day
75	11	0	..... hrs. ..... min.

9. Birthplace: Poolesville, Montg Co. Md (Town, county, and state)
10. Usual occupation: House keeping
11. Industry or business
FATHER 12. Name: John R. Hall
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sallie E. Hickman
15. Birthplace: Maryland
16. Informant: Miss Mary Hall
Address: Poolesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2-45 (month) (day) (year)
Cemetery or crematory: Monocacy
Location: Beallsville, Md
18. Funeral director: Wm B. Hilton
Address: Barnesville, Md
19. Oct. 1, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30 1945 at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/23 1942, to 9/30 1945
and that I last saw h[illegible] alive on 9/30 1945

Immediate cause of death	DURATION
Cardio-vascular Renal Disease	5 yrs.+
Due to: Arteriosclerosis	10 yrs.+
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Byron D. White, M.D.
M. D. or other
Address: Poolesville, Md Date signed: 10/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-01)

CERTIFICATE OF DEATH

(9134)

Reg. Dist. No. 1223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1914 Capitol View Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr. Andrew James Hamilton

3.(b) Social Security Number 214-12-7418

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Mary Hamilton

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1898

8. AGE: Years 46 | Months 11 | Days 21 | If less than one day hrs. min.

9. Birthplace Rutherford, New Jersey

(Town, county, and state)

10. Usual occupation Manager

11. Industry or business Laundry

FATHER 12. Name Unknown

FATHER 13. Birthplace N. J.

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace N. J.

16. Informant Russell Nash, Funeral Home

Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 22, 1945 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Bladensburg Rd., Md

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. 45 Sept 21 19 45 (Date rec'd by registrar) J. A. Priddy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 19 45, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to Sept 21 19 45

and that I last saw h... alive on Sept. 20 19 45

Immediate cause of death	DURATION
Cardiac failure	2 days
Uremia	2 weeks
Due to Hypertension	3 years +
Due to Nephrosclerosis	over 3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. C. Kolb M.D. M. D. or other

Address Washington Sanitarium & Hospital, Takoma Park, Md. Date signed 9-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

★ 19135 214
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~XXXXXXXXXX~~ street address where death occurred:
8407 Dixon Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8407 Dixon Ave., Apt. 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EDWIN IRVING HARMON

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ or wife: Maude E. Harmon
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 27, 1877

8. AGE: Years	Months	Days	If less than one day
68	1	2	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Retired Decorator
11. Industry or business

FATHER
12. Name: John O. Harmon
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Ida Mary Stickles
15. Birthplace: Washington, D. C.

16. Informant: Mrs. Maude E. Harmon
Address: 8407 Dixon Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 2, 1945 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D. C.
18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Maryland

19. Oct 1 19 45 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 19 45 at 12:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 19 45, to Sept. 29 19 45
and that I last saw h.. alive on September 29 19 45

Immediate cause of death	DURATION
Myocardial infarction and coronary artery occlusion	18 hrs.
Due to generalized arterio-sclerosis	10 years
Due to diabetes mellitus	22 years
Other conditions: Subacute hypelonephritis, left	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Clarence Rice M. D.
M. D. or other
Address: 1150 Conn. Ave., Wash. D.C. Date signed: 9/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

★ 19136

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Montgomery Co. General Hospital, Inc.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewboro infants give resideoce of motber)
State Maryland County Montgomery
City or town Laytonsville
(If outside city or town limits, writs RURAL and give oearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Ann Hawkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Mr Albert Hawkins
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 6, 1898

8. AGE:	Years	Months	Days	If less than one day
	47	6	15	..... hrs. ..... min.

9. Birthplace Montgomery Co - Md.
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business
FATHER 12. Name Lyde Griffith
13. Birthplace Maryland
MOTHER 14. Maiden name Julia Knauffer
15. Birthplace Maryland
16. Informant Hospital records
Address Olney, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept 23-1945 (month) (day) (year)
Cemetery or crematory Laytonsville Md
Location Montgomery County
18. Funeral director Roy W. Barber
Address Laytonsville Md
19. Sept. 22 1945 (Date rec'd by registrar) Gertrude B. Lamb Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1945, at 8 10 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/18/45 to 9/21/45 and that I last saw h.. alive on 9/20/45

Immediate cause of death	DURATION
acute tracheobronchitis	2 days
Due to Congenital Patent Foramen Ovale	Life
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE J. W. B.
M. D. or other
Address Sandy Spring Md Date signed 9/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

09137

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Wytheville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. #4
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HEDGE, Charles Mack, S2c V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 24 Aug. 1925

8. AGE: Years	Months	Days	If less than one day
20	1	2	hrs. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER
12. Name: Jessie Hedge
13. Birthplace: Va.

MOTHER
14. Maiden name: Fairy Myers
15. Birthplace: Va. (deceased)

16. Informant: father: Mr. Jessie H. Hedge
Address: Wytheville, Va. Rt. #4

17. removal (Burial, cremation, or removal. Which?) Date thereof: 9-27-45 (month) (day) (year)

Cemetery or crematory: New West End

Location: Wytheville, Va.

18. Funeral director: Geo. M. Wise J.C.F.
Address: 2900 M St., N. W., Wash., D. C.

19. 9-27 19 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 Sept. 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 Aug. 1945 to 26 Sept. 1945 and that I last saw h... in... alive on 26 Sept. 1945

Immediate cause of death	DURATION
Bronchopneumonia	1 week
Due to: Leukemia Acute Lymphatic	1 Month
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. B. HAYLES, Lt. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(9/30/45)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

09138

Reg. Dist. No. 212

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Barnesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty.

City or town: Barnesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Arthur Crosley Hersberger

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Valinda J. Hersberger

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Feb. 16 1876

8. AGE:

Years	Months	Days	If less than one day
69	6	15	hrs. min.

9. Birthplace: Poolesville, Monty. Md. (Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business

FATHER

12. Name: Aaron Hersberger

13. Birthplace: Md.

MOTHER

14. Maiden name: Hester Whipp

15. Birthplace: Md.

16. Informant: Valinda J. Hersberger

Address: Barnesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 (month) 3 (day) 45 (year)

Cemetery or crematory: Monocacy

Location: Beallsville, Md.

18. Funeral director: Wm. B. Hilton

Address: Barnesville, Md.

19. Sept 2 1945 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. C.C.H. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1 — 1945 at 4:20 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/26 1944, to 9/1 1945 and that I last saw him alive on 9/1 1945

	DURATION
Immediate cause of death	
Chronic cardio-renal —	
Due to: Vascular disease with hypertension	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Byron D. White, M.D. M. D. or other

Address: Poolesville, Md. Date signed 9/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

09139

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? died on admission

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? died on admission

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Calif. County

City or town Manhattan Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No. 130 19th St.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME HESTER, Rolf Kingsley, RT 1c V-6 USNR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-6-1924

8. AGE: Years 21 | Months 0 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Calif.
(Town, county, and state)

10. Usual occupation Navy

11. Industry or business

FATHER 12. Name O. C. Hester

13. Birthplace Calif.

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Father: Mr. O. C. Hester

Address 130 19th St., Manhattan Beach, Calif.

17. removal (Burial, cremation, or removal. Which?) Date thereof 9-1-45 (month) (day) (year)

Cemetery or crematory Forest Lawn Memorial Park

Location Glendale, Calif.

18. Funeral director Geo. W. Wise

Address 2900 M St., N. W., Wash., D.C.

19. 1 Sept. 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 September 1945 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from (died on admission) 19..... to 19.....

and that I last saw him alive on 1 Sept. 1945

	DURATION
Immediate cause of death: Pneumonitis acute	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results Pneumonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE F. E. CHATARD, Lt. Cdr. (MC) USN
M. D. or other

Address US N.H., Bethesda, Md. Date signed 9-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

9/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9140

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution: Suburban Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4545 Wilson Lane

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Miss Mabel Hutchings

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 11, 1885.

8. AGE:

Years	Months	Days	If less than one day
60	4	30	hrs. min.

9. Birthplace: Michigan (Town, county, and state)

10. Usual occupation: Accountant

11. Industry or business:

FATHER — 12. Name: Charles E. Hutchings

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Margaret E. Niblock

15. Birthplace: Pa.

16. Informant: Mr. Roe Hutchings

Address: 4545 Windsor Lane

17. (Burial, cremation, or removal. Which?) Cremation Date thereof 9/13/45 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cem.

Location: Maryland

18. Funeral director: W. Reuben Dunphrey

Address: 7557 Wis. Ave. Bethesda Md.

19. 9/13 (Date rec'd by registrar) 19 45 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10, 1945, at 7:39 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 31 1945, to Sept 10 1945, and that I last saw her alive on Sept. 10 1945.

Immediate cause of death	DURATION
Intracerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Richard E. Kelso M.D. M. D. or other

Address: Bethesda, Md Date signed: 8-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

09141

CERTIFICATE OF DEATH

~~STATE G98 OCT 26 1945~~ ★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Rural Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 mins. - after birth

Hospital, institution, or street address where death occurred: Suburban Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town R.F.D. #3 - Mount Zion

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. # 3

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Infant Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	—

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1945

8. AGE: Years — Months — Days — If less than one day — hrs. 28 min.

9. Birthplace Montgomery Co. Bethesda Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden name Infant Johnson

15. Birthplace Mount Zion Md.

16. Informant Infant Johnson

Address Mount Zion Md.

17. (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 9/24 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1945, at 8:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/20 1945, to 9/20 1945

and that I last saw h.. l.. alive on 9/20 1945

Immediate cause of death	Neo natal death	DURATION
Due to	failure to breathe	
Due to	prematurity (5 mos fœtus)	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. S. T. Kimble, Jr. M. D. or other

Address Bethesda Suburban Hosp. Date signed 9/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09142 2/8

Reg. Diat. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Rt. Brookville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Howard Chapel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Maria S. Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	married

6.(b) Name of husband or wife: Charles W. Johnson

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): May 9 1923

8. AGE: Years	Months	Days	If less than one day
22	3	21	...hrs. ...min.

9. Birthplace: Howard Co Md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Home

FATHER

12. Name: Eugene Darry

13. Birthplace

MOTHER

14. Maiden name: Nanatta Snowden

15. Birthplace: Howard Co. Md

16. Informant: Nanatta Darry

Address: Brookville Md 16-

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16 1943 (month) (day) (year)

Cemetery or crematory: Mt Gregary

Location: Cooksville Md

18. Funeral director: Roy W. Barber

Address: Laytonsville Md

19. 9/14/43 (Date rec'd by registrar) L D Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1943, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 Dead Exam 19 to 19

and that I last saw h... alive on ... 19

Immediate cause of death	DURATION
Acute Cardiac dilatation	1/2 hr.
Due to: Chronic Valvular heart	
Due to: disease	3 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bonstead M. D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed: 9-13-43

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09143

Reg. Diat. No. 216

1. PLACE OF DEATH: Montgomery
County Montgomery Co
City or town Chevy Chase Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
9 Hesketh St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Hesketh St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Cecil K Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Lois C Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 10, 1872

8. AGE: Years	Months	Days	If less than one day
73.			hrs. min.

9. Birthplace Va
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Jones -
13. Birthplace Va
MOTHER 14. Maiden name
15. Birthplace
16. Informant Lois C Jones -
Address 9- Hisketh st. Chevy Chase.
17. Cremation Date thereof 9/27/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rock Creek Cem
Location D.C.
18. Funeral director J. Wm Lee & Son
Address 305 - 4th St N.E. Wash DC
19. 9/25 1945 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25 1945 at 4 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15 1945 to 9-25 1945
and that I last saw h alive on 9-24 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2-3 yrs?
Tuberculous Laryngitis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

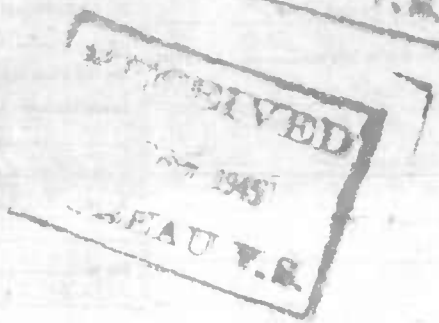
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. R. Huffman M.D.
M. D. or other
Address 17 Dupont Circle Date signed 9/25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
SEP 27 1945
BUREAU V.S.

RECEIVED
1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09144

Reg. Dist. No. 2-16

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Dist. of Col. County

City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3901 Connecticut Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna M. Keenan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1884

8. AGE: Years	Months	Days	If less than one day
60	8		hrs. min.

9. Birthplace Saugerties, New York
(Town, county, and state)

10. Usual occupation Unemployed - Home

11. Industry or business

FATHER

12. Name Joseph Keenan

13. Birthplace Saugerties, New York

MOTHER

14. Maiden name Ella Hoben

15. Birthplace Saugerties, New York

16. Informant Mae F. Keenan (sister)

Address 3901 Connecticut Ave., Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9/1/45 (month) (day) (year)

Cemetery or crematory

Location Washington D C

18. Funeral director Martin W. Hyson

Address 1300 N. St. NW.

19. 9/1 1945 Wm E Jobard
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1941 to Sept 1 1945 and that I last saw h... alive on 8/31/45 1945

Immediate cause of death	DURATION
Auricular fibrillation	
with decompensation	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Richard V. Mattingly M.D.
M. D. or other

Address 4707 Conn Ave. NW. Wash DC Date signed 9/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

09145

M

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Mont Registration Dist. No. 716

Village or City Beth. Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Loretta M. Lee If U. S. Veteran, specify WAR

(a) Residence: No. 4807 Hampden Lane St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John M Lee

6. DATE OF BIRTH (month, day, and year) June 27. 1902

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. H.W

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Mo (State or country)

FATHER

13. NAME John H Mayo

14. BIRTHPLACE (city or town) Mo (State or country)

MOTHER

15. MAIDEN NAME Mary De Cantor

16. BIRTHPLACE (city or town) Mo (State or country)

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Wash. D.C. Date Sept 11, 1945

19. UNDERTAKER W. Warren Tallyrull (Address) 3619-14th St NW Wash. D.C

20. FILED 9/11, 1945 Mrs E Jolley Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept 11 (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 21, 1943, to Sept 11, 1945

I last saw h-- alive on 9/11/45, 19; death is said to have occurred on the date stated above, at 10:30 p m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Tuberculosis	1942
1) of Kidney & Bladder	
2) of Lungs	
3) of G.U. Tract	

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Paul D Cantor M. D.

(Address) 7425 Wisconsin Ave

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

09146

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 hours

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 10 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. Westchester Apartments

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME
Anna H. MEADE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Capt. B. V. Meade

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 23, 1867

8. AGE:	Years	Months	Days	If less than one day
	78	6	29	..... hrs. ..... min.

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: W. D. Hamilton
13. Birthplace: Scotland

MOTHER
14. Maiden name: Sara Abbott
15. Birthplace: Ohio

16. Informant: Husband: Capt. B. V. Meade
Address: Westchester Apts., Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9-25-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Joseph Gawler's Sons. K.Ax.
Address: 1750-58 Penn. Ave., N.W., Washington, D.C.

19. Sept 23 1945 (Date rec'd by registrar) mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 22 1945, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 and present at death. 19.. to 19..

and that I last saw her alive on Sept 22 5:45 P.M. 1945

Immediate cause of death	DURATION
Heart failure	
Due to: Auricular fibrillation	
Toxemia of Pregnancy	
Due to: intestinal obstruction	4 days.
Due to old operative adhesions. cured.	
Other conditions: Not due to cancer.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: No autopsy was performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: F. E. Hebb M.D. (M. D. or other)

Address: U.S.N.H. Bethesda, Md. Date signed: 9-23-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

09147

CERTIFICATE OF DEATH

Reg. Diat. No. 276

1. PLACE OF DEATH:

County Montg

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, Institution, or street address where death occurred:
4843 Cordell Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montg

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4843 Cordell Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war No.

3. (a) FULL NAME William LeRoy Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Divorced

6.(b) Name of husband or wife Mary K.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 19, 1887

8. AGE: Years	Months	Days	If less than one day
58	5	24	..... hrs. ..... min.

9. Birthplace Watsontown Pa.
(Town, county, and state)

10. Usual occupation Accountant

11. Industry or business

FATHER
12. Name Samuel Miller
13. Birthplace Patterson, Pa.

MOTHER
14. Maiden name Martha Yerg
15. Birthplace Pa.

16. Informant Mrs. Blanche Drake
Address 4843 Cordell Ave. Bethesda

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 9/14/45 (month) (day) (year)

Cemetery or crematory Cleveland, Ohio.

Location Ohio.

18. Funeral director Wm Reuben Humphreys
Address 7557 Wis. Ave. Bethesda, Md.

19. 9/14 1945 Wm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1945 at 9:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. 19 ..... to case 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary occlusion	hrs. suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Brochant M.D.
Dep. Med. Exam. M. D. or other

Address Hagerstown Md. Date signed 9-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. G 98 OCT 4 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

09148

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Farmers Lane Rockville md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Farmers Lane Rockville md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Howard B. Nichols

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) March 15 1925

8. AGE: Years	Months	Days	If less than one day
20	5	26	hrs. min.

9. Birthplace West Va Rom Co
(Town, county, and state)
10. Usual occupation —
11. Industry or business —
FATHER 12. Name Henry W Nichols
FATHER 13. Birthplace Rom Co W. Va
MOTHER 14. Maiden name Okie Seibolt
MOTHER 15. Birthplace Rom Co W. Va
16. Informant Mrs Okie Nichols
Address Farmers Lane Rockville md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12 1945 (month) (day) (year)
Cemetery or crematory Flower Hill Redland md
Location Montgom Co md
18. Funeral director Col W. Barber
Address Gaithersville md
19. Mrs Josephine D. Hamilton (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1945 at 5:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1941 to Sept. 10 1945 and that I last saw h. alive on September 10 1945

Immediate cause of death	DURATION
Epilepsy	8 years.
Due to —	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Esther F. Kuhn M.D.
M. D. or other
Address Rockville, Md. Date signed 9/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164c)

CERTIFICATE OF DEATH

Reg. Diat. No. 09142 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5½ days

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 5½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6619 Strathmore

(If rurol, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Caroline Novak

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Martin P. Novak

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1875

8. AGE: Years	Months	Days	If less than one day
70		9	hrs. ..... min.

9. Birthplace Raleigh, North Carolina (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name W. Ezekial Young

13. Birthplace North Carolina

MOTHER 14. Maiden name Sherady

15. Birthplace North Carolina

16. Informant Mrs. Sally Novak Schmidt sister-in law

Address 10000 Granger Rd., Cleveland 5, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/29/45 (month) (day) (year)

Cemetery or crematory Arlington Natl. Cem.

Location Virginia

18. Funeral director Wm. Reuben Dunphrey

Address 7557 Wis. Ave. Bethesda, Md.

19. 9/27 1945 (Date rec'd by registrar) Wm E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1945 at 2:45 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. Med Exam case 19.. to 19..

and that I last saw h.. alive on 19..

Immediate cause of death	DURATION
Lobar pneumonia	2 days
Due to bullet wound thru lower lobe left lung	6 days
Due to (accident),	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 9-20-45

Where did injury occur? Chevy Chase (City or town) Mont. (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchart M.D. M. D. or other

Address Gaithersburg Md. Date signed 9-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

09150

★ Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Montg.

City or town Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 yrs.

Hospital, institution, or street address where death occurred: 4901 River Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.

City or town Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4901 River Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie R. Perry.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife Benjamen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1857

8. AGE:

Years	Months	Days	If less than one day
88	8	20	..... hrs. ..... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John W. Brewer

13. Birthplace Md.

MOTHER 14. Maiden name Luciendo Dyer

15. Birthplace Virginia

16. Informant C. Elf Perry

Address 4011 Fessenden St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/28/45 (month) (day) (year)

Cemetery or crematory Cedar Hill Cem.

Location Maryland

18. Funeral director Wm Reuben Dunphrey

Address 7557 Wis. Ave. Bethesda

19. 9/27 (Date rec'd by registrar) 1945 Wm E. Forbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/45 19.... at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/19/1945 to 9/25/ 1945

and that I last saw h.. alive on Sept. 25, 1945

Immediate cause of death Cerebral Hemorrhage — DURATION 16 days

Due to Chr. arteriosclerosis — 10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emil G. Bauerfeind M. D. or other

Address Bethesda, Md. Date signed 9/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4th)

09151

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Pr. Geo.

City or town Glendale

(If outside city or town limits, write RURAL and give nearest town)

Street No. Glendale San.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edwin Stanton Phillips

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1864

8. AGE: Years	Months	Days	If less than one day
81	7	28	..... hrs. ..... min.

9. Birthplace Mahanoy, Penna. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name DAVID PHILIPS

13. Birthplace PENNA.

MOTHER 14. Maiden name SARAH A MOLE

15. Birthplace PENNA.

16. Informant Records, Wash. Sani. Hospital

Address Takoma Park, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13, 1945. (month) (day) (year)

Cemetery or crematory Union Hill Cemetery.

Location Kennett Square, Penna.

18. Funeral director Arthur Walters.

Address 234 Carroll St. N.W. Takoma Park, D.C.

19. (Date rec'd by registrar) SEP 11 1945 J. Wm Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27 1945 to Sept 10 1945 and that I last saw h alive on Sept. 1945

Immediate cause of death	DURATION
Intestinal Obstruction	2 weeks
Due to Metastatic Carcinoma generalized of abdomen	1 yr. +
Due to Carcinoma of rectosigmoid	5 yrs.
Other conditions Myocardial degeneration Auricular Fibrillation	

(Include pregnancy within 3 months of death)

Major findings of operations No Operation this adm. Carcinoma rectosigmoid Date of op. Feb-1945

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Leon L. Calvert M.D. M. D. or other

Address 7894 Eastern Ave S.S. Md Date signed 9-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

09152

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or Institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 813 Bonifant St.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME
GEORGE W. PHILLIPS

3.(b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ or wife: Florence G?
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 28th. 1861

8. AGE: Years	Months	Days	If less than one day
84	7	11	..... hrs. ..... min.

9. Birthplace: Wash. D. C. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Charles L. Phillips
13. Birthplace: Unknown

MOTHER
14. Maiden name: Cordelia Dean
15. Birthplace: Unknown

16. Informant: Harry C. Davis (nephew)
Address: Chastleton Hotel (1701 - 16th. St.) Wash. D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/11/45 (month) (day) (year)
Cemetery or crematory: Congressional
Location: Washington, D. C.
18. Funeral director: Daniel E Cumphrey -
Address: 8434 Ga. Ave. Silver Spring. Md.

19. Sept 10 1945 Josephine M Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 1945, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4 1945, to Sept. 9 1945 and that I last saw h... alive on Sept. 8 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions: Intestinal Hemorrhage 5 days. Due to Ca. of intestines ?	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Marion Blanchard M.D.
M. D. or other
Address: Silver Spring, Md. Date signed 9/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

09153

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Minn. County:

City or town: Minneapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2324 McNaill Ave., N.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

POTVIN, Lyle Adolph, Pfc USMC

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 28 March 1919

8. AGE: Years	Months	Days	If less than one day
26	5	22	hrs. min.

9. Birthplace: Minn. (Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Mrs. June Potvin
15. Birthplace: unknown

16. Informant: Mother: Mrs. June Potvin
Address: 2324 McNaill Ave. N., Minneapolis, Minn.

17. removal (Burial, cremation, or removal. Which?) Date thereof 9-21-45 (month) (day) (year)

Cemetery or crematory:

Location: Minneapolis, Minnesota

18. Funeral director: Geo. W. Wise F F

Address: 2900 M St., N. W., Wash., D.C.

19. 9-20 19 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 Sept. 19 45 at 9:40P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Sept. 19 45, to 19 Sept. 19 45 and that I last saw h in alive on 19 Sept. 19 45

Immediate cause of death	DURATION
Peritonitis, Generalized acute	10 days
Due to: Wound, Gunshot Abdomen	10 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Perforations of jejunum and colon Date of op. Sept 9, 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of Sept 9, 1945

Where did injury occur? Anacostia (City or town) D.C. (County) D.C. (State)

Injured at home, farm, industry, public place (where?): Anzio

Means of injury: Gunshot Injured at work? Yes

23. SIGNATURE: C. E. Hesselton Lt (cdr) MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 9-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54-6)

CERTIFICATE OF DEATH

★ 09154

Reg. Diat. No. 213-

1. PLACE OF DEATH:

County Montgomery County

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all of Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Flora Powell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 9, 1869

8. AGE: Years	Months	Days	If less than one day
76	11	20	— hrs. — min.

9. Birthplace Quince Orchard, Montg. Md.
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Alfred Ross

13. Birthplace Maryland

MOTHER 14. Maiden name Janie Lee

15. Birthplace Maryland

16. Informant Gertrude Mc Knight

Address Rockville Md. (Daughter)

17. Burial Date thereof Sept. 23, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Haiti Cemetery

Location Rockville, Md.

18. Funeral director Robert L. Snowden

Address Rockville, Maryland

19. Sept. 22 1945 Josephine D. Hoxton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1945 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1945, to Sept. 19 — 1945, and that I last saw her alive on Sept. 18 — 1945.

Immediate cause of death	DURATION
Senility	10 yrs
Due to Arthritis —	20-30 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Miller M. D. or other

Address Gaithersburg, Md Date signed 9/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

09155 ★ Reg. Diat. No. 216

1. PLACE OF DEATH:
County 116 Wooten Ave -
City or town Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs -
Hospital, Institution, or street address where death occurred:
116 Wooten Ave. Friendship Hgts!
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty Md.
City or town Friendship Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 116 Wooten Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles W. Rippey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife Nina S.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1873

8. AGE: Years	Months	Days	If less than one day
72	6	4	..... hrs. ..... min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual occupation Teacher
11. Industry or business
FATHER 12. Name John S. Rippey
13. Birthplace N. Y.
MOTHER 14. Maiden name Harriett E. Wheadon
15. Birthplace N. Y.
16. Informant Josephine Rippey
Address 116 Wooten Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/11/45 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cem.
Location Maryland
18. Funeral director Wm Reuben Pumphrey
Address Bethesda, Md.
19. 9/10 1945 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9th 1945, at 3 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945, to date 1945
and that I last saw him alive on Sept 9th 1945

Immediate cause of death	DURATION
Heart Block	1 wk.
Due to Arteriosclerosis	10 yrs.
Due to Endocarditis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Truman Orr Jr M. D. or other
Address 3744 Huntington Pl N.W. Date signed 8/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

09156

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1741 - K St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Roberts, Mrs. Fanny A.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Owen C. Robert
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 4, 1891

8. AGE:

Years	Months	Days	If less than one day
54	7	5	hrs. min.

9. Birthplace: Cleveland, Ohio
(Town, county, and state)
10. Usual occupation: Music teacher
11. Industry or business: own

FATHER
12. Name: Noah S. Armstrong
13. Birthplace: Wayne Co, Ohio

MOTHER
14. Maiden name: Cynthiana Wilbur Moore
15. Birthplace: Cleveland, Ohio

16. Informant: Rhoads, Wash. Sani. Hospital
Address: Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9/9/45 (month) (day) (year)

Cemetery or crematory:
Location:

18. Funeral director: The S. H. Hines Co
Address: 2901-14 - St. N. W. Washington D.C.

19. 9/9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 1945 at 4:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1944, to Sept 9 1945
and that I last saw h[illegible] alive on Sept 8 1945

Immediate cause of death	DURATION
Glomerulo Nephritis Chronic	10 mos
Due to: Hypertension Cardio-Vascular Disease	9 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry L. Brown M.D. M. D. or other
Address: Wash. San. Takoma Park Md. Date signed: 9-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09157

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-4)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Mich. County:

City or town: Kalamazoo,
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: RYDER, Leslie, Cpl. USMC

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Leslie Ryder

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1922

8. AGE:	Years	Months	Days	If less than one day
	23	6	18	hrs. min.

9. Birthplace: Mich.
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Wife: Mrs. Leslie Ryder
Address: 1729 21st St., N. W., Wash., D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 9-21-45 (month) (day) (year)

Cemetery or crematory:

Location: Kalamazoo, Mich.

18. Funeral director: Geo. W. Wise F.F.
Address: 2900 M St., N. W., Wash., D.C.

19. 9-20 (Date rec'd by registrar) 1945 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 Sept. 1945, at 6.05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Sept. 1945, to 20 Sept. 1945 and that I last saw h... in ...alive on 20 Sept. 1945

Immediate cause of death	DURATION
Extra cranial injury and	
Fractured skull.	
Due to motorcycle accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: accident Date of: 9-19-45

Where did injury occur? Scott Circle, Wash., D.C.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): public place

Means of injury: motorcycle accident Injured at work? yes

23. SIGNATURE: Collin S Mac Coll, M. D. or other

Address: US Naval Hospital, Bethesda, Md. Date signed: 9-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09158

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
8312 Carey Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8312 Carey Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Henry W. Henry Schiesser

3. (b) Social Security Number: 094-07-2041

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 10, 1907

8. AGE: Years	Months	Days	If less than one day
38	7	9	..... hrs. ..... min.

9. Birthplace: New York, N.Y.
(Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: —

FATHER
12. Name: Henry Schiesser
13. Birthplace: Long Island, N.Y.

MOTHER
14. Maiden name: Mary Mitchell
15. Birthplace: Ireland

16. Informant: Mrs. Henry Schiesser
Address: 5842 Mt. Liska, N.Y.

17. Burial — Date thereof: Sept. 22, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Bedford Union Cemetery
Location: Bedford, New York

18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. Sept 20 1945 Josephine McHaedle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1945, at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1945, to Sept 19 1945
and that I last saw h... alive on Sept 19 1945

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
M. D. or other
Address: Gaithersburg Md. Date signed: 9-19-1945

09159

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County Moneg.
City or town Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs.
Hospital, Institution or street address where death occurred:
218 Prospect St. Ch. Ch. Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Moneg.
City or town Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 Prospect St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Lillie N. Seabold

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife William A.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1870

8. AGE: Years	Months	Days	If less than one day
75	7		..... hrs. ..... min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Chas. L. Hughes
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Laura V. Gardner
15. Birthplace Washington D.C.

16. Informant Helen Seabold
Address Daughter In Law

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/5/45 (month) (day) (year)
Cemetery or crematory Glenwood Cemetery
Location Washington D.C.

18. Funeral director Wm Reuben Dunphrey
Address 7557 Wis. Ave. Bethesda Md

19. 9/5 (Date rec'd by registrar) 19 45 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1945 at 6:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 1945 to Sept. 2 1945 and that I last saw h...ed ...alive on Sept 2, 1945

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to Coronary Arteriosclerosis	
Due to	
Other conditions Carcinoma of Stomach	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. T. Sydenstricker M.D. M. D. or other
Address 2143 - Suitland Rd. Date signed 9-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-a)

09160

CERTIFICATE OF DEATH

Reg. Dist. No. 226

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Suburban Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Falls Rd.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR World War I

3. (a) FULL NAME George Marion Steads

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8 (b) Name of husband or wife Dorothy Inez Steads

6(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) March 10, 1892

8. AGE: Years	Months	Days	If less than one day
53	6	2	hrs. min.

9. Birthplace Riceyville, Virginia (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name John D. Steads

13. Birthplace Virginia

MOTHER 14. Maiden name Jocie Cropp

15. Birthplace Virginia

16. Informant Dorothy Steads

Address Falls Rd, Rockville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/17/45 (month) (day) (year)

Cemetery or crematory Arlington Nath. Cem.

Location Virginia

18. Funeral director Wm Reuben Plumphrey

Address Bethesda, Md.

19. 9/14 (Date rec'd by registrar) 19 45 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 19 45, at 6:55 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 19 45, and that I last saw h alive on Sept 12 19 45

Immediate cause of death	DURATION
Internal Hemorrhage	
Due to Crushed Chest	1½ hrs
Due to Among Tractor when upset	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 9-12-45

Where did injury occur? Rockville (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury Tractor Injured at work? yes

23. SIGNATURE Frank J Broschart M.D.

Dep. Med. Exam. M. D. or other

Address Gaithersburg Md Date signed 9-12-45

09161

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore No-C

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, Institution,~~ or street address where death occurred:
2108 Evans Parkway
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2108 Evans Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Sue Carol Simmons

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —
6.(c) If olive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1940

8. AGE: Years	Months	Days	If less than one day
4	10	13	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Stiles B. Simmons
13. Birthplace Atlanta, Ga.

MOTHER
14. Maiden name Cleo S. Voit
15. Birthplace North Carolina

16. Informant Stiles B. Simmons
Address 2108 Evans Parkway, Silver Spring Md.
17. Burial Date thereof Sept 24, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln Cemetery
Location Bladensburg Rd., Md.
18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.
19. Sept 23 1945 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1945 at 11:35 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 21 1945 to 1945
and that I last saw h... alive on ... 1945

Immediate cause of death	DURATION
Crushed skull	killed instantly
Due to: struck by automobile	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 9-21-45
Where did injury occur? Silver Spring (City or town) Mont. (County) Md. (State)
Injured at home, farm, industry, public place (where?) highway
Means of injury auto Injured at work? no

23. SIGNATURE Frank J. Broschart M.D.
Dep. Med. Exam. M. D. or other
Address Gaithersburg Md. Date signed 9-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING


RECEIVED
SEP 26 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 2191

19162 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montg. Co. Gen. Hosp.
City or town: Olney Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days -
Hospital, institution, or street address where death occurred:
Olney Md
How long in hospital or institution? 3 days -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Howard
City or town: Daylon — Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mrs Florence Smallwood

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: William W Smallwood
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 26, 1869

8. AGE: Years	Months	Days	If less than one day
75	11	3	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: At home
11. Industry or business:
FATHER 12. Name: William H Gelbart
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary Harding
15. Birthplace: Md.
16. Informant: Mrs. Turner Nichols.
Address: Clarksville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-3-45 (month) (day) (year)
Cemetery or crematory: St Marks.
Location: Highland. Md
18. Funeral director: P. C. Higinbotham
Address: Ellicott City Md
19. Oct. 2, 1945 (Date rec'd by registrar) John B. Laughman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 - 1945 at 7:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 - 1945, to Sept 29 - 1945
and that I last saw h.. alive on Sept 29 - 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas E Smallwood M. D. or other
Address: Sandy Spring Md. Date signed 9/29/45

Evidence for change of age is shown on [illegible] No. G 98 SEP 18 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

09163

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Glen Echo Heights Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 6209 Walhonding Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Glen Echo Hts.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6209 Walhonding Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Maude E. Southwick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Harvey Southwick

Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 12-12-1876

8. AGE: Years	Months	Days	If less than one day
68 69	9	8	hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER 12. Name: Wm. Ford

13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Annetta Blodgood

15. Birthplace: Baltimore, Md.

16. Informant: Howard F Hilton

Address: Trinity Terrace - 14th & Columbia Rd.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 9/11/45 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cem.

Location: Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda Maryland

19. 9/10 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/8 1945 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/26 1945 to 9/8 1945 and that I last saw h alive on 9/3 1945.

	DURATION
Immediate cause of death: Cerebral thrombosis	3 wks.
Due to: Cerebral arteriosclerosis	?
Due to:	
Other conditions: Essential hypertension (Include pregnancy within 3 months of death)	?

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Bernard J. Walsh M. D. or other

Address: 900 - 17th St. N. W. Wash. D. C. Date signed: 9/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09164

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
Baby Girl Stacey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 23 Sept. 1945

8. AGE: Years	Months	Days	If less than one day
			one hrs. min.

9. Birthplace: Bethesda, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Mae Emaline STACEY
15. Birthplace: Maine

16. Informant: Mo: Mae Emaline Stacey
Address: USNaval Hospital, Bethesda, Md.

17. (Burial, cremation, or removal. Which?) Date thereof: 9-24-45 (month) (day) (year)

Cemetery or crematory: Pathological Department

Location: Naval Medical School, Bethesda, Md.

18. Funeral director: Pathological Dept.,

Address: National Naval Medical Center, Bethesd, Md.

19. 24 Sept. 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 Sept. 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: born prematurely	6 mo.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: B. Gillespie B. GILLESPIE, Lt. (MC) USNR
M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 9-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9165

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: Monty

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Monty

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 Montpelier St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John W. Stewart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Effie R. Stewart

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 20, 1892

8. AGE: Years	Months	Days	If less than one day
53			..... hrs. ..... min.

9. Birthplace: Kensington Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Edward Stewart

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Sophia Terry

MOTHER — 15. Birthplace: Virginia

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7, 1945 (month) (day) (year)

Cemetery or crematory: Linden Cemetery

Location: Linden, Maryland

16. Funeral director: R. L. Snowden.

Address: 246 N. Wash. St Rockville, Md.

19. Sept 7 1945 Josephine M. Keefe (Date rec'd by registrar) Registrar

Effie

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4 1945, at 7:15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 4 1945 to ..... 19..... and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute cardiac dilatation	1/2 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bronhart M.D. Dep. Med. Exam. M. D. or other

Address: Hagerstown Md. Date signed 9-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09166

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery Co Md
City or town: Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4604 Brandt
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ELIZABETH AGNES SULLIVAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widow

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 1867

8. AGE — Years	Months	Days	If less than one day
77	11		hrs. min.

9. Birthplace: Wash DC (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER — 12. Name: James Sweeny
13. Birthplace: Ireland
MOTHER — 14. Maiden name: Ellen O'Tool
15. Birthplace: Ireland
16. Informant: Helen Waite
Address: Lynbrook NY
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/7/45 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cem
Location: Wash DC
18. Funeral director: S H Hines Co
Address: 2901-14 St, N.W.
19. 9/5 1945 Wm E Jolley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/5 1945 at 4:08 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940 to Sept 5 1945
and that I last saw h alive on Sept 4 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: Arteriosclerosis	10 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Bruce T. Benjamin MD
M. D. or other
Address: Bethesda, Md. Date signed 9/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (116-e)

CERTIFICATE OF DEATH

09167

★ Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montg
City or town: Suburban Hosp. Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Monty
City or town: Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Harry Swank

3. (b) Social Security Number: 579-039-903

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Caroline Swank
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): July 17

8. AGE: Years	Months	Days	If less than one day
913. 32	1	22	hrs. min.

9. Birthplace: Manty & Md (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: William S Swank
13. Birthplace: Va

MOTHER
14. Maiden name: Mary F. Hilderbrand
15. Birthplace: Md

16. Informant: Mrs. Lo Swank
Address: Dickerson. md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 11-45 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Hyattstown, Md
18. Funeral director: Wm B. Hilton
Address: Barnesville, Md.

19. 9/10 1945 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 19 45; at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage	4½ hrs.
Due to: rupture of spleen	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of 9-8-45
Where did injury occur? Clarksburg (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?) highway
Means of injury auto accident Injured at work? no

23. SIGNATURE: Frank J. Brockhurst M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md Date signed 9-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

59168

Reg. Diat. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? eight days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? eight days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.J. County:

City or town: Elizabeth
(If outside city or town limits, write RURAL and give nearest town)

Street No. 56 Geneva St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

SZOPA, Alexander John, S/Sgt. USMCR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 12, 1923

8. AGE: Years	Months	Days	If less than one day
22	1	8	hrs. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business

FATHER
12. Name: Anthony Szopa
13. Birthplace: Poland

MOTHER
14. Maiden name: Stella Szurly
15. Birthplace: Poland

16. Informant: fa: Mr. Anthony Szopa

Address: 56 Geneva St., Elizabeth, N.J.

17. removal (Burial, cremation, or removal. Which?) Date thereof 9-21-45 (month) (day) (year)

Cemetery or crematory:

Location: Elizabeth, N.J.

18. Funeral director: Geo. W. Wise 9C7.

Address: 2900 M St., N. W., Wash., D.C.

19. Sept. 21 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 Sept. 19 45 at 8:52P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Sept. 19 45 to 20 Sept. 19 45 and that I last saw h in alive on 20 Sept. 19 45

Immediate cause of death	Cerebral edema	DURATION
Due to	Brain Tumor	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: Malignant Tumor of Cerebellum Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Allen S. MacCarty M. D. or other

Address: Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

09169

Reg. Dist. No. 2-14

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred: 9013 - 1st Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9013 - 1st Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: SARAH BUSHROD SKILLMAN VEIRS

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: SAMUEL JOSEPH VEIRS

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): OCT 3 1861

8. AGE: Years	Months	Days	If less than one day
83	11	18	... hrs. ... min.

9. Birthplace: LOUDEN Co. VA.

(Town, county, and state)

10. Usual occupation: SEAMSTRESS

11. Industry or business: FRANK R TELLEFES

FATHER

12. Name: BUSHROD SKILLMAN

13. Birthplace: LOUDEN CO. VA

MOTHER

14. Maiden name: SARAH GOCHENAUER

15. Birthplace: LOUDEN CO. VA.

16. Informant: Mrs. Lester Veirs

Address: 9013 1st Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 25 - 1945 (month) (day) (year)

Cemetery or crematory: George Wash. Mem Cemetery

Location: Riggs Rd. Pr Georges Co. Md

18. Funeral director: Warner E. Pumphrey

Address: 8438 Ga Ave. Silver Spring. Md

19. Sept 24 1945 (Date rec'd by registrar) Josephine M. Schaefle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 1945 at 9:55 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1936 to Sept 21 1945

and that I last saw her alive on Sept 21 1945

Immediate cause of death	DURATION
Acute Cardiac dilatation	2 days
Due to: Hypertension	15 years
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Mitchell M.D. M. D. or other

Address: Silver Spring Md Date signed: 9-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coverage is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09170

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★Reg. Dist. No. 213.

1. PLACE OF DEATH:

County Monty

City or town Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, Institution, or street address where death occurred:
26 Wall St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Monty

City or town Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 Wall St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Malinda Waters.

3.(b) Social Security Number

4. Sex	5. Color or race	7.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife Washington

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 23, 1877

8. AGE: Years	Months	Days	If less than one day
68	5	2	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Solomon Yearley
13. Birthplace Md.

MOTHER
14. Maiden name Jane Samuels
15. Birthplace Del.

16. Informant Anna Yearley

Address 26 Wall St. Rockville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/27/45 (month) (day) (year)

Cemetery or crematory Rockville Union Cem.

Location Rockville, Md.

18. Funeral director Wm Reuben Dunphrey

Address Rockville, Md.

19. 9/26/45 (Date rec'd by registrar) Josephine D. Hilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/1945, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10. 1945, to Sept 25, 1945 and that I last saw h alive on Sept. 20, 1945

Immediate cause of death	DURATION
Coronary occlusion	10 days
Due to Chronic arteriosclerosis	10 yrs.
Due to * Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ethel G. Beverley M.D.
M. D. or other

Address Bethesda Md Date signed 9/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

19171

Reg. Diat. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N. C. County:

City or town: Lexington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 N. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WHEELER, Avery Thomas, Slc V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-3-26

8. AGE:	Years	Months	Days	If less than one day
	19	6	17	hrs. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Jess Allen Wheeler
13. Birthplace: N.C.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Wife: Mrs. J. A. Wheeler
Address: 221 N. Main St., Lexington, N.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof 9-21-45 (month) (day) (year)

Cemetery or crematory:

Location: Lexington, N.C.

18. Funeral director: Geo. W. Wise, F.E.
Address: 2900 M St., N. W., Wash., D.C.

19. 9-20 19 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 Sept. 19 45 at 7:22 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Aug. 19 45, to 20 Sept. 19 45 and that I last saw him alive on 20 Sept. 19 45

Immediate cause of death	DURATION
Cerebral edema	
Due to: Brain Tumor.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Glio blastoma J The Gors. Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Collis L. Mac Canly, M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 9-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9172

★ Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Monty.

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs -

Hospital, Institution, or street address where death occurred: 5507 Charles St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Monty

City or town Ala Vista Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5507 Chas. St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Ann Estelle Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife Frank Wilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1881

8. AGE: Years	Months	Days	If less than one day
65			..... hrs. ..... min.

9. Birthplace Bethesda, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Henry B. Kiner
13. Birthplace Wash. D.C

MOTHER
14. Maiden name Mary E. Bean
15. Birthplace Wash. D.C.

16. Informant Ernest W. Kiner

Address 5507 Chas. St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/15/45 (month) (day) (year)

Cemetery or crematory Mt. Zion Cem.

Location Maryland

18. Funeral director Lew Reuben Humphrey

Address Bethesda Md.

19. 9/14 19 45 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1945 at 5:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 42 to Sept 19 45 and that I last saw her alive on Sept 12 19 45

Immediate cause of death	DURATION
Uremia	
Due to Nephritis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lew Reuben Humphrey M. D. or other

Address 4016 Dent Pl Date signed 9/13/45